Welcome to Tufts Health Plan

TUFTS Health Plan
No one does more to keep you healthy.

Please complete all of the employee sections of the membership application in full. Failure to do so could delay enrollment.

Member Sections

Personal Information - Complete all enrollment information. If your plan requires the selection of a primary care physician (HMO, POS, or EPO), please be sure to fill out this section for all members, including dependents.

Primary Care Physician - To find a primary care physician, visit our Web site, www.**tuftshealthplan**.com, click on Doctors, Fitness Centers and More, and use the physician search feature. A member services coordinator can also help, just call the appropriate number below.

Student dependents - If you have a dependent who is a full-time student, you will be required to submit proof of full-time student status twice a year. Please be sure to fill out all appropriate information for each dependent, including primary care physician (if applicable).

Other Health Coverage - If you have other insurance (including Medicare) please check the correct box and fill in the additional information about your other insurance. If you do not have other insurance, be sure to check the no box.

Employer Section

This section must be filled out by your employer.

When the Application is Complete

The employee should keep the yellow copy.
The employer should keep the pink copy.
The original (white copy) is for Tufts Health Plan.

Tufts Health Plan
P.O. Box 9186
Watertown, MA 02471-9186

Need Help?

If you need assistance selecting a primary care physician or filling out this form, our member services coordinators are here to help.

800-462-0224
TDD 800-815-8580 or
800-868-5850

You can also log on to our Web site at www.**tuftshealthplan**.com for more information.

We speak 140 languages.
Call for translation services:

Nous parlons français
Hablamos Español
Nós falamos português
Мы говорим по-русски
Parliamo Italiano
Wir sprechen Deutsch
我們會講普通話
我們會講廣東話
Chúng tôi nói được tiếng Việt
Nou pale Kreyòl

Please Note:

By enrolling, you agree to and understand that if you or any of your enrolled dependents (a) obtain a health care benefit or payment that you know you are not entitled to receive or be paid; or (b) knowingly present or cause to be presented, with fraudulent intent, a claim that contains a false statement, you can be liable for the full amount of the health care benefit or payment made and for reasonable attorney's fees and costs, including cost of investigation.

TUFTS Health Plan
No one does more to keep you healthy.

Member Enrollment Form

Please print or type.
please be sure application is completed in full to ensure enrollment.

Enrollment/Eligibility • PO Box 9186 • Watertown, Massachusetts 02471-9186

Employer Section

FAILURE TO COMPLETE AREAS MARKED IN BLUE MAY CAUSE A DELAY IN ENROLLMENT.

1. Name of Employer or Group	2. Group Number	3. Date of Hire	4. Effective Date of Coverage
5. Office Location	6. Type of Enrollment ☐ New Hire ☐ Open Enrollment ☐ COBRA ☐ New Group ☐ Qualifying Event (MUST specify)_____		7. Qualifying Event Date

Member Section

8. Last Name	9. First Name	10. Middle Initial	11. Employee Social Security Number (SSN)
12. Mailing Address (Home address)	13. Apt#	14. City	15. State
16. ZIP	17. Gender ☐ M ☐ F	18. Date of Birth month / day / year	
19. Marital Status ☐ Single ☐ Separated ☐ Widowed ☐ Married ☐ Divorced ☐ Other _____	20. Type of Coverage Requested ☐ Individual ☐ Family ☐ Other _____	21. Primary Care Physician (HMO,POS,EPO only)	22. PCP ID# / 23. Check if currently used for primary care ☐
24. Home Telephone ( )	25. Work Telephone ( )	26. Fitness Center	27. Primary Language

Members Enrolling (Last name, if different)	Sex M/F	Date of Birth	if dependent is over age 19 - Please Check One: Full time Student	Disabled	Social Security Number	Fitness Center	DO NOT WRITE IN THIS SPACE	Choose a **Primary Care Physician** for each member (HMO/POS/EPO only)	Tufts Health Plan Affiliated Hospital	check if currently used for primary care	PCP ID#
28. Spouse					- -						
29. Child/Dependent					- -						
30. Child/Dependent					- -						
31. Child/Dependent					- -						
32. Child/Dependent					- -						
33. Child/Dependent					- -						

34. Do you or someone else covered under this insurance policy have other health insurance coverage at the same time your Tufts Health Plan policy is in effect? ☐ Yes ☐ Yes (Medicare) ☐ No

Name of Health Plan | Name of Plan Holder | Health Plan Number

Effective Date | Names of Family Members Covered

35. Is spouse employed? ☐ Yes ☐ No If yes, Name and Address of Employer

36. Please check If you are using additional membership applications for additional dependent children ☐

37. Does spouse or dependent have different address? ☐ Yes ☐ No If YES, please provide permanent address:

The information supplied on this form is true and complete. I authorize my employer to make necessary payroll deductions, if any, for my share of Tufts Health Plan coverage. I assign benefits to Tufts Health Plan providers, which means that Tufts Health Plan is authorized to make payment directly to Tufts Health Plan providers for services rendered to me (us). I grant Tufts Health Plan any legal right that I (or we) may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid by Tufts Health Plan. I understand that calls to the member services department may be monitored for quality assurance. I understand that the benefits for which I (we) are eligible are those described in the applicable member benefit documents.

Signature (required): _____ **Date:** _____ **Benefits Dept. Signature:** _____ **Telephone:** _____ **Date:** _____

WHITE - TUFTS HEALTH PLAN COPY PINK - EMPLOYER COPY YELLOW - SUBSCRIBER COPY. Please keep yellow copy as your temporary Tufts Health Plan I.D.

Thank You for Choosing Tufts Health Plan

TUFTS Health Plan
No one does more to keep you healthy.

You will receive your ID card and member benefit document soon.

Choose a primary care physician (if necessary)

It is important that you choose a primary care physician immediately if your plan requires one. Failure to receive services or get authorization from your primary care physician could mean a significant reduction in benefits, except in an emergency. If you need help choosing a primary care physician, please use the physician search feature of our Web site (go to www.tuftshealthplan.com and click on Doctors, Fitness Centers and More) or call a member services coordinator.

If you are selecting a new primary care physician, contact that doctor immediately. Introduce yourself as a new member and find out whether your physician would like to schedule a physical exam. Transfer your medical records to your new primary care physician immediately.

If you need emergency care

In an emergency, go to the nearest medical facility or call 911. An emergency is a serious injury or the onset of a serious condition that prevents you from taking the time to call your primary care physician (if your plan requires one).

Have questions or need help?

Just give one of our member services coordinators a call at:

800-462-0224
TDD 800-815-8580 or
800-868-5850

Or log on to our Web site at www.**tuftshealthplan**.com for helpful information.

Tufts Health Plan arranges for the provision of health care services, but does not provide health care services. Tufts Health Plan arranges for the provision of health care through agreements with independent community-based health care professionals working in private offices and with hospitals throughout the Tufts Health Plan service area. These providers are independent contractors and not employees, agents, or representatives of Tufts Health Plan for any purposes.

18079-1/06